Executive Directive 2
Governor's Work Group on Rural Obstetrical Care

Interim Report

Secretary of Health and Human Resources

July 1, 2004

Executive Summary

The Commonwealth of Virginia is facing a health care crisis, as many women in rural areas have limited access to necessary obstetrical care. Due to the convergence of multiple barriers, such as stagnant Medicaid reimbursement, increasing costs for professional liability insurance, and a growing number of uninsured, several hospitals have closed their obstetrical care units or are facing closure, and obstetrical providers are refusing to see Medicaid patients or are leaving the Commonwealth for states with more favorable environments. To address this problem, Governor Warner signed Executive Directive 2 (Appendix A), which directed the Secretary of Health and Human Resources (the Secretary) to convene and chair the Rural Obstetrical Services Work Group.

The Secretary was also directed to evaluate the obstetrical crisis in Item 298 of the 2004-2006 Appropriation Act. The Appropriation Act language (Appendix B) expands the review of obstetrical care to all areas of the state. Due to the similarity of the issues and to prevent duplication of efforts, the Secretary intends to issue one report in the Fall of 2004 to meet both the Executive Directive and Appropriation Act requirements.

The crisis in obstetrical care is not defined by a single loss of a provider or a single closure of a hospital. Instead, it is the growing trend of hospitals, especially in rural areas, cutting, closing, or considering closure of their obstetrical units. For example, just in the last eight months, the following hospitals, all in rural areas, have cut back on obstetrical services:

- Bon Secours St. Mary's Hospital, Norton
  - obstetrical services suspended in November 2003
- Russell County Medical Center, Lebanon
  - obstetrical services suspended in November 2003
- Alleghany Regional Hospital, Low Moor
  - obstetrical services cut in December 2003
- Rappahannock General Hospital, Kilmarnock
  - obstetrical services cut in December 2003

As the existing crisis was not created by one isolated event, the solution will not be found in a single intervention by the Commonwealth, but through a comprehensive plan targeting a variety of barriers to access. The plan will not be limited to rural areas, but will address barriers to access in all underserved areas of the state. The Work Group will develop the plan over the summer months and present the final recommendations in the Fall 2004. However, the members have identified two preliminary recommendations that may relieve some of the immediate pressure on the system, persuade providers to continue taking Medicaid patients, and offer evidence that the Commonwealth understands the urgency of the situation. The preliminary recommendations are presented below:

Preliminary Recommendation #1: The Governor should provide emergency authority and funding for the Department of Medical Assistance Services to increase the Medicaid physician fee schedule for Obstetrical and Gynecological services by 44.91 percent through the emergency regulation process.

Preliminary Recommendation #2: The Department of Medical Assistance Services should increase the income standard to allow pregnant women up to 200 percent of the federal poverty limit to be eligible for Medicaid benefits.

Formation of the Work Group

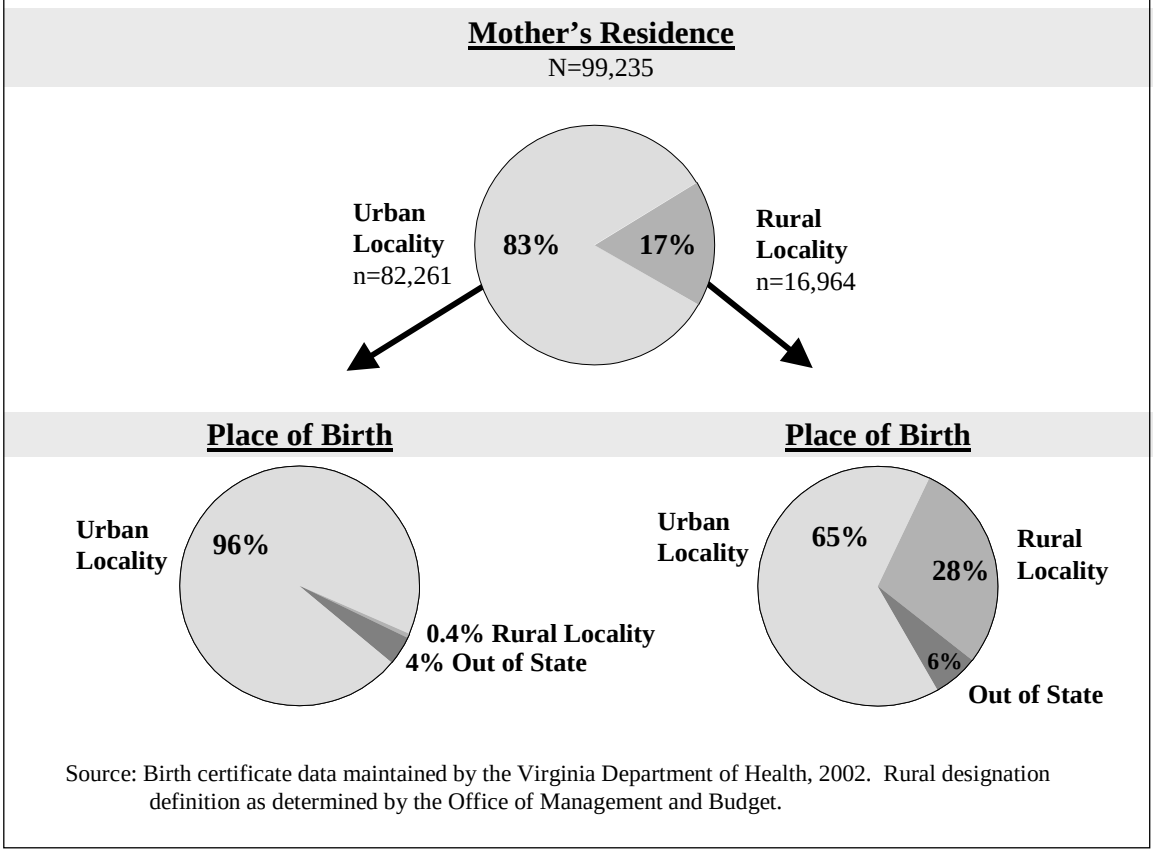
The Work Group was convened on May 5, 2004 and met again on June 9, 2004. The membership includes, among others, members of the Virginia General Assembly, physicians, such as obstetricians, family practitioners, pediatricians, and neo-natologists, a certified nurse midwife, a certified professional midwife, trial attorneys, and representatives from local governments, health plans, health insurance companies, non-profit organizations, the academic health centers, and professional associations (Appendix C). Staff to the Workgroup includes the Virginia Department of Health (VDH), the Department of Medical Assistance Services (DMAS), and the Bureau of Insurance (BOI). At least one more Work Group meeting will be held in September, 2004.

The members have embarked on an ambitious array of research activities to evaluate four specific issues that we believe directly influence the availability of obstetrical care: 1) quality of care, 2) reimbursement, 3) medical malpractice, and 4) barriers to access. To facilitate the work, the Secretary has assigned four subcommittees to address each of these issues. This interim report describes the status of each of the four subcommittee's efforts and identifies the major research activities to be completed this summer. The final report, which will be completed in the Fall 2004, will include final recommendations for promoting adequate access to prenatal, obstetrical, and postnatal care.

Before discussing the efforts of the subcommittees, some background on obstetrical care in both rural and non-rural areas of Virginia may be useful. Based on the definition of rural used by the Office of Management and Budget (OMB), there are 73 rural localities in Virginia, including several independent cities such as Galax, Martinsville, and Harrisonburg (Appendix D). The OMB is in the process of implementing a new methodology for determining a rural area based on commuting trends using the 2000 Census. Using the new methodology, as many as 17 localities would no longer be considered rural. However, since the new methodology has not yet been implemented, the Work Group will continue to consider all 73 localities rural.

In 2002, there were 99,235 live births in Virginia, of which 17 percent were to women who lived in rural localities. As shown in Figure 1, women who resided in urban localities almost exclusively delivered their babies in urban localities. However, 65 percent of women who resided in rural localities delivered their babies in urban localities. Many of these women may live on the edge of an urban locality, and therefore are not traveling far to

Figure 1
Live Births in Virginia in 2002 by Rural Designation of Mother's Residence and Place of Birth



Source: Birth certificate data maintained by the Virginia Department of Health, 2002. Rural designation definition as determined by the Office of Management and Budget.

access care in the urban area. Therefore, for the final report, the Work Group will be conducting an analysis to determine the distance women travel to deliver based on the zip code of the mother and the zip code of the place of delivery. This analysis, combined with information about the primary service areas of the state's hospitals, will yield important information about consumer behavior in the use of obstetrical care.

Quality of Care Subcommittee

The Quality of Care subcommittee is exploring the appropriate standard of care for prenatal, delivery, and postnatal services and the extent to which rural community hospitals with relatively few births each year face special challenges in meeting the standard. Agreement was tentatively reached among the subcommittee members that the combined American College of Obstetricians and Gynecologists (ACOG)/American Academy of Pediatrics Guidelines for Obstetrical Care should be accepted as the standard for Virginia. This action agrees with other organizations, including the Regional Perinatology Councils.

Reimbursement Subcommittee

The reimbursement subcommittee is evaluating the extent to which reimbursement is a factor in the rural obstetrical care crisis and will recommend options for change. It was immediately apparent to the subcommittee members that an isolated examination of reimbursement would not fully address conditions that have led to this crisis, and that while improving reimbursement levels may contribute to the solution, it would only be a part of a comprehensive approach to this crisis.

Because of the program's design related to its eligibility criteria, Medicaid is a prominent payer for obstetrical care in Virginia, particularly for the delivery of babies. Medicaid recipients can be a significant percentage of a hospital's or physician's overall utilization for these types of services. Medicaid as a percent of total utilization for these services is often higher in rural areas due to the socio-economic status of some rural communities, the loss of jobs in rural areas, and the smaller amount of available providers relative to urban and suburban areas that naturally occurs due to population density.

Preliminary research indicates that Medicaid rates are both lower than cost and lower than private insurance rates. Historical fee-for-service (FFS) Medicaid reimbursement rate information shows that Virginia has paid, on average, from 70 to 80 percent of hospitals' inpatient Medicaid costs for a number of years now across all services (the reimbursement system is designed to take a discount off of estimated costs). The subcommittee has not yet examined Medicaid payments and hospital costs relative to obstetrical services only, but by shear design of the Medicaid reimbursement system, one would not expect a substantially different result.

Medicaid reimbursement to physicians is most likely significantly below cost as well. Cost data for physicians is more difficult to come by, so the subcommittee has focused thus far on a comparison of Medicaid rates relative to what Medicare would pay. Virginia's Medicaid rates are based on the same methodology utilized by Medicare, however, Virginia does not distinguish rates based on region and has imposed a budget neutrality factor in physician rates that has kept rates fairly constant since 1992. For the upcoming State Fiscal Year (SFY) 2005, current estimates show Medicaid physician rates to be approximately 69 percent of the equivalent Medicare rates, or 31 percent below the estimated payment level in Medicare.

In addition to Medicaid rates being lower than cost for hospitals and physicians, the gap between Medicaid and private insurance rates continues to grow. Preliminary analysis indicates that, for certain service codes relevant to obstetrical services, current Medicaid rates are approximately 60 percent of the commercial rates for the same types of services. This estimate is preliminary, and the subcommittee intends to provide a more thorough analysis if more comprehensive rate data can be obtained for commercial health plans and Medicaid Managed Care Organizations (MCOs).

Low Medicaid reimbursement rates, high Medicaid utilization in rural areas, and high liability insurance premiums have converged to create an unstable financial environment for hospitals and physicians providing obstetrical care. As one example, Rockingham Memorial

Hospital, in Harrisonburg, is facing a crisis in that several of their obstetricians are choosing to leave Virginia due to the current financial environment. This hospital, which delivered 1,814 babies in FY 2002, is the service center for many rural communities. If this hospital were to close its obstetrical unit, the results could be increased use of the emergency department for deliveries, which may not be equipped or trained to handle the increased utilization, a clear gap in access to services, and a severe health care crisis for women in the area.

Though the Work Group will be making recommendations in the Fall 2004 related to a comprehensive plan to recommend what steps the Commonwealth should undertake to improve access to obstetrical care, the subcommittee recommends that in the short term, Medicaid rates for obstetrical care delivered by physicians should be raised. This would relieve some of the immediate pressure on the system, persuade providers to continue taking Medicaid patients, and offer evidence that the Commonwealth understands the urgency of the situation.

Specifically, the Work Group is recommending that the Governor give DMAS the authority to promulgate emergency regulations to modify physician payment rates for obstetrical services (including gynecological services) to increase Medicaid payment rates by approximately 45 percent (to roughly equate to Medicare rates for these services). The Work Group estimates that a budget increase to DMAS of approximately $19 million (9.5 million GF) on an annual basis would be necessary to implement this recommendation. The Work Group recommends that the effective date of this rate change be as early as possible relative to the emergency regulation process, and the Work Group is aware that in order to receive the federal match, an approved State Plan amendment would be required.

> ***Preliminary Recommendation #1:*** The Governor should provide emergency authority and funding for the Department of Medical Assistance Services to increase the Medicaid physician fee schedule for Obstetrical and Gynecological services by 44.91 percent through the emergency regulation process.

Support of similar increases for Medicaid pediatric services rates, particularly newborn baby visits, exists as well, and the Work Group recommends high consideration of a payment increase for pediatric services equal to that formally recommended for obstetrical services. The Work Group intends to further study pediatric services rates to provide a formal recommendation relative to needed rate increases in the final report to be developed this fall.

Additionally, the Work Group believes that automatic inflation adjustments should be built into the Medicaid physician reimbursement methodology in order to provide annual rate changes that track with changes in the cost of providing care. The reimbursement subcommittee will be clarifying how this methodology change should be accomplished along with estimates of the costs of such a change for formal recommendation in the final report.

While the information the reimbursement subcommittee has examined to date clearly supports the notion that Medicaid payment rates are low compared with other payers, and some reimbursement increases will certainly be a part of any comprehensive approach to the impending crisis in access to obstetrical care, the subcommittee is clear that a reimbursement

increase alone is not the complete answer to this crisis. The subcommittee is concerned that other factors, such as rising malpractice premiums and low volume in rural areas, are contributing to the access issue, and throwing money at these problems may not be the correct approach. As such, the subcommittee will tackle the following research questions for the final report in order to better determine both the extent of reimbursement needs and how best to target reimbursement increases:

- How does a provider's payer mix contribute to the impact of reimbursement on access to care?
- What is driving the cost of obstetrical care?
- How do we quantify the respective roles malpractice premiums, publicly-funded reimbursement levels, and volume of deliveries play in determining the availability of obstetrical care?

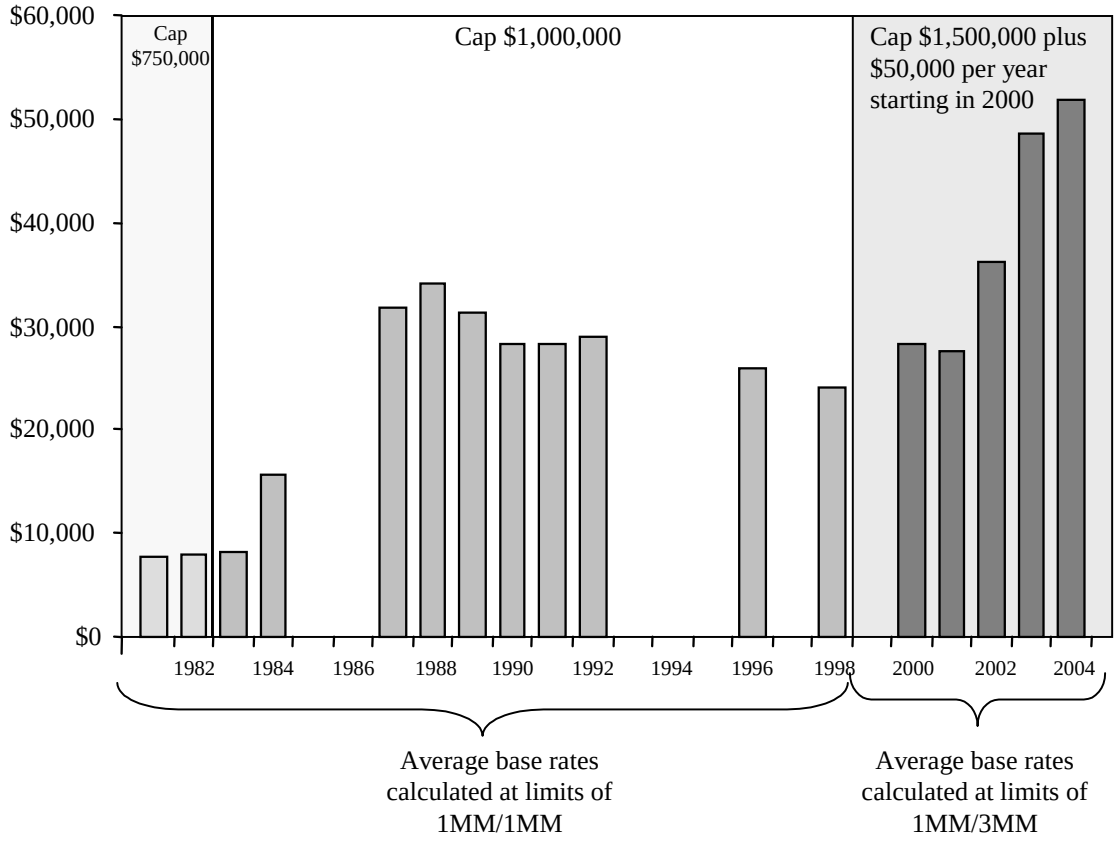
Medical Malpractice Subcommittee

The Medical Malpractice subcommittee was charged with evaluating the problems faced by providers of obstetrical services from a malpractice insurance standpoint. The subcommittee identified potential problems faced by medical service providers and facilities and collected information on Virginia physician claim frequency and severity trends, territorial rate differentials between providers of malpractice insurance for hospitals and physicians, and comparisons of premiums paid by physicians over the past 20 years.

For example, Figure 2 illustrates the trend in composite base rates over the last 23 years. As shown, the base rate grew from $27,507 in 2001 to $51,847 in 2004, an 88 percent increase to its highest level in 23 years. The subcommittee members have also reviewed reports on the effectiveness of tort reforms, availability of malpractice insurance in Virginia, the reasonableness of rates charged physicians in Virginia, and whether a joint underwriting association should be formed in Virginia.

Based on a review of the collected data, including the information presented in Figure 2, the subcommittee concluded that, overall, the cost of medical malpractice insurance is a factor in the provision of obstetrical care in the context of fixed revenues and rising practice costs. However, addressing the medical malpractice premiums alone will not assure access to obstetrical care in Virginia. The subcommittee will be discussing possible interventions with respect to medical malpractice insurance that could improve access to and the provision of obstetrical care and will be making recommendations in the final report. In considering the options, the subcommittee will evaluate whether the interventions should be statewide or targeted to underserved areas, as well as evaluate how the interventions will affect the system as a whole.

Figure 2
Average Statewide OB/GYN Base Rates



Source: Various House Documents, the Medical Liability Monitor and actual insurance company filings made with the Bureau of Insurance.

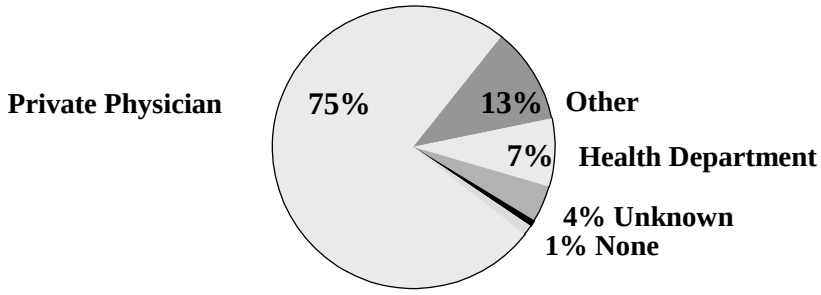
Barriers to Access Subcommittee

The Barriers to Access Subcommittee is identifying barriers to obstetrical access. Clearly two of the most salient barriers are reimbursement rates and medical malpractice insurance rates. However, two subcommittees have been established to look specifically at those financial issues. Therefore, the members of this subcommittee are focusing on the structural and cultural barriers to women receiving necessary prenatal, delivery, and postnatal care.

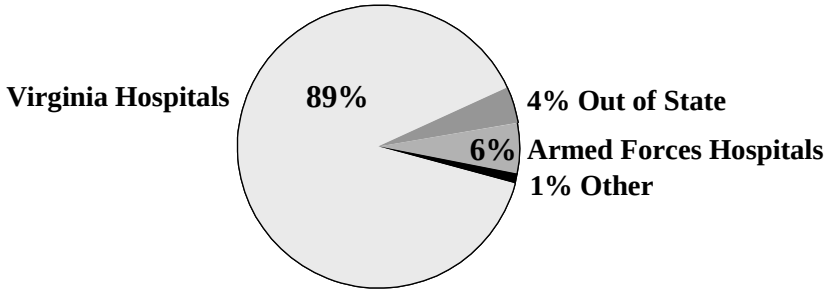
Structural barriers are those produced by the current service delivery model in Virginia. According to the subcommittee members, the predominant service delivery model is prenatal, delivery, and postnatal care provided by an obstetrician at a physician practice, hospital, or clinic. This model is illustrated in Figure 3, which shows that of the live births in Virginia in 2002, the majority occurred at a hospital and were attended by a physician. In addition, prenatal care was provided by a physician in three quarters of the pregnancies. There was some deviation from this model, as seven percent of the women received prenatal care from the local health departments and a certified nurse midwife attended seven percent of the births. The

Figure 3
Live Births in Virginia in 2002
(N=99,235)

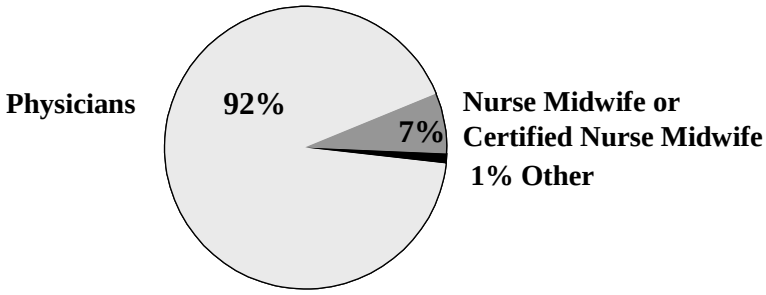
Source of Prenatal Care



Facility of Birth



Attendant to the Birth



Source: Birth certificate data maintained by the Virginia Department of Health, 2002. Rural designation definition as determined by the Office of Management and Budget.

subcommittee members have identified the following barriers to access related to the prominent service delivery model:

- **The number of obstetrical providers in many rural areas of Virginia may not be sufficient to meet the service delivery needs.** Anecdotal evidence suggests that providers are increasingly unwilling to serve Medicaid patients or even practice obstetrics in Virginia. Clearly, economic factors such as reimbursement rates and medical malpractice insurance rates, which are being evaluated by other

subcommittees, may be driving this trend. However, this subcommittee will look at other options for expanding provider presence in rural areas.

- **Licensure and regulatory requirements limit access to certain types of providers.** Currently in Virginia, certified nurse midwives may provide obstetrical care to women under the supervision of a physician. CNMs are nationally certified to provide well woman gynecological care as well as prenatal, delivery, and prenatal care in hospital, birthing centers, and home environments. Typically, certified nurse midwives in Virginia provide delivery care in a hospital setting. Certified professional midwives (CPM) are not licensed to provide prenatal, delivery, or postnatal care in Virginia. CPMs are nationally certified with the ability to provide prenatal, delivery, and postnatal services in the home environment.

- **There are low-income women in Virginia who do not have private health insurance but are not eligible for Medicaid.** Without insurance, these women may not be receiving prenatal medical care that may support a positive pregnancy outcome. The current Medicaid program covers pregnant women up to 133 percent of the federal poverty level. As a preliminary recommendation, the Commonwealth may want to consider raising the Medicaid income limits to allow more pregnant women to be eligible for Medicaid.

Preliminary Recommendation #2: The Department of Medical Assistance Services should increase the income standard to allow pregnant women up to 200 percent of the federal poverty limit to be eligible for Medicaid benefits.

- **Communication of patient information among the key providers of obstetrical services is inadequate.** As discussed above, the predominant service delivery model in Virginia involves women receiving prenatal, delivery, and postnatal services from an obstetrician. However, for women on Medicaid or without insurance, this model may not apply. For example, in some localities, local health departments or a local physician provides the prenatal care, with delivery occurring at a hospital outside of a mother's home community. The members of the subcommittee are concerned that, in these cases, information does not flow from the providers of prenatal care to the provider who delivers the child. Such communication is essential to positive outcomes.

- **Several hospitals have closed, or may close, their obstetrical units.** Last year, Rappahannock General Hospital closed its obstetrical unit. As discussed above, Rockingham Memorial Hospital is facing financial stress that may lead to closure of its obstetrical unit. The results of this trend may be 1) an increased distance for women to travel for obstetrical services, 2) an increase in the use of emergency departments for deliveries, and 3) poor clinical outcomes.

- **Emergency and non-emergency transportation may be insufficient to meet the needs of pregnant women.** This is especially a concern as hospitals close their obstetrical units.

Over the last eight years, there has been considerable study of the issue of access to obstetrical care by state agencies and commissions. Each study recommends specific fixes, which would band-aid some of the aforementioned structural barriers. However, the larger issue is whether the existing service delivery model is appropriate for all parts of the state. This subcommittee is in the process of identifying alternative models that may be appropriate for rural areas, including regional magnet centers with local prenatal and postnatal care (the North Carolina model), or increased availability of birthing centers. These various models, including our current model, will be evaluated on specific criteria, such as safety, cultural impact, and stability. As part of the evaluation, the subcommittee will consider mechanisms for 1) evaluating the availability of prenatal, obstetrical, and postnatal care on an ongoing basis, and 2) intervening in the system when a hospital or provider is considering suspension of services. This review of the structural model as a whole may result in a recommendation for a new paradigm for rural areas.

The subcommittee is also examining cultural and social issues that may prevent women from accessing obstetrical care. Members of the subcommittee are concerned that the current system is not sensitive to the various cultures and cultural expectations of women in Virginia. The number of families of diverse cultures continues to grow, as evidenced by the growth in the foreign-born population in Virginia. Between the 1990 and 2000 Census, the foreign-born population grew from five percent to eight percent of the population in the Commonwealth (2003 Joint Legislative Audit and Review Commission report on the "Acclimation of the Foreign-Born Population"). This trend is not driven by urban areas alone; in many rural communities, up to five percent of the population is now foreign-born, with a handful of rural communities with 10 percent born outside of the United States. The specific cultural and social issues for consideration by the subcommittee include:

- **An increase in undocumented aliens, who may not have access to health care, has put additional stress on the system.** The actual number of undocumented aliens (individuals not legally present in Virginia) living in Virginia is not available. However, the Immigration and Naturalization Service estimates that the number of undocumented aliens in Virginia grew from 55,000 in 1996 to 103,000 in 2000. This is a growth of 87 percent in four years. These individuals do not have access to Medicaid or FAMIS, except for emergency services.

- **There is a failure of some pregnant women to access services, even if obstetrical care is available.** Some women may not perceive prenatal care to be valuable. The subcommittee members understand that this will be a difficult issue to address, but feel that it is important to document the extent to which it may be a problem.

- **Community and cultural expectations differ from available service options.** There may be a perception that each community should have a hospital fully staffed for all types of deliveries, for example, when the volume does not support such an institution.

- **Lack of culturally sensitive and culturally competent providers.** Some women may prefer to receive care from a female provider, or a provider of the same ethnicity.

Many rural communities do not have the volume to support the array of preferred providers.

Major Research Activities

Each of the subcommittees will be completing a number of research activities during the summer months. The major activities that are relevant to the entire workgroup are listed on the next page.

Public Hearings. The Work Group will be holding public hearings in five regions of the Commonwealth. Work Group members and staff will be present to hear feedback from diverse groups, including obstetricians, hospital administrators, patients/patient advocate groups, nurses, pregnant women, women who have received the services under discussion, etc. The hearings will be an opportunity for the members to hear opinions on the quality and accessibility of obstetrical care delivered in various communities.

Survey of Other States. Virginia is not alone in facing a crisis in obstetrical care. ACOG has named 13 states, including Virginia, as Red Alert Crisis states, stating that they are facing a crisis in the availability of care. Since other states are in a similar situation, the subcommittees will contact various states to determine what solutions have been implemented and how successful those interventions have been. Each of the subcommittees will contribute questions to the survey instrument, and the survey will be conducted in the months of July and August.

Survey of Health District Directors. One of the tasks of the Work Group is to determine the extent of the crisis in obstetrical services. Therefore, the members will inventory the resources currently available from non-profit organizations, federally funded clinics, and public-private partnerships. To this end, health district directors will be surveyed, as they are on the front lines of assisting families find and maintain prenatal, delivery, and postnatal care. In addition, this survey will attempt to identify best practices of how rural areas are dealing with this problem with existing resources. Each of the subcommittees will contribute questions to the survey instrument, and the survey will be conducted in the months of July and August.

Data Analysis. Over the last several weeks, the Work Group has collected data from various sources, including Virginia Health Information, the Virginia Hospital and Healthcare Association, the Department of Medical Assistance Services, the Bureau of Insurance, and the Department of Health. Over the next several months, staff will be evaluating these data and exploring various trends. Through this analysis, the members will be able to evaluate potential solutions to this crucial problem.

Appendix A

COMMONWEALTH OF VIRGINIA

OFFICE OF THE GOVERNOR

Executive Directive 2

Importance of the Issue

Prenatal, obstetrical, and labor and delivery services are a critical component of any modern society's health care system. Prenatal care, obstetrical and labor and delivery services in a community help ensure healthy babies.

A complex combination of factors ranging from third party reimbursement to malpractice insurance premiums has limited the availability of this care in certain rural areas of the Commonwealth. Most recently, this problem has occurred in the Northern Neck, though problems with access to care in rural areas have also developed in Southside and Southwest Virginia.

By virtue of the authority vested in me as Governor under Article V of the *Constitution of Virginia* and under the laws of the Commonwealth, including but not limited to Chapter 1 of Title 2.2, I hereby create the Governor's Working Group on Rural Obstetrical Care.

The Working Group

The working group will initially consist of 17 members. Additional members may be appointed by the Governor at his discretion. The working group will be chaired by the Secretary of Health and Human Resources. The group shall include but shall not be limited to representatives of: the Virginia Hospital & Healthcare Association; the Medical Society of Virginia; the American College of Obstetrics and Gynecology, Virginia Chapter; the Virginia Trial Lawyers Association; and other entities as determined by the Governor. Staff support will be provided by the Office of the

Appendix A

Governor, the Office of the Secretary of Health and Human Resources, the Department of Health, and the Department of Medical Assistance Services.

Responsibilities of the Working Group

The working group will be responsible for the following:

1) Reviewing relevant executive branch policies that may serve as an impediment to providing needed care in rural areas of the Commonwealth;
2) Developing the executive branch's response to legislatively mandated studies and coordinating the executive branch's response to and work with any other study groups examining similar issues;
3) Reviewing best practices in other states;
4) Making policy recommendations as may seem appropriate to the Governor and General Assembly regarding improving access to care in rural areas.

The working group shall also examine other issues as may seem appropriate.

Reporting Requirements

The working group shall issue a preliminary report to the Governor by July 1, 2004 and a final report to the Governor by October 1, 2004. The preliminary and final reports shall also be provided to the Chairmen of the House Appropriations Committee; the House Committee on Health, Welfare, and Institutions; the Senate Committee on Finance; the Senate Committee on Education and Health; and the Joint Commission on Health Care.

Effective Date of the Executive Directive

This Executive Directive shall be effective upon its signing and shall remain in full force and effect until March 13, 2005, unless sooner amended or rescinded by further executive directive.

Given under my hand this 13th day of March 2004.

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Mark R. Warner, Governor

Appendix B

2004-2006 Appropriation Act Language

Item 298 of the 2004-2006 Appropriation Act:

"The Secretary of Health and Human Resources, in cooperation with the Bureau of Insurance in the State Corporation Commission, shall report on the availability of obstetrical services in the Commonwealth and identify any areas of the Commonwealth where there is inadequate access to such services. The report shall include information on (i) the factors contributing to inadequate access to services; (ii) the availability and affordability of malpractice insurance for obstetricians; (iii) any specific problems regarding access to obstetrical care for Medicaid and Family Access to Medical Insurance Security enrollees; and (iv) an assessment of the degree to which these factors may be contributing to the lack of access to obstetrical care in certain areas of the Commonwealth. The report shall make recommendations on actions that can be taken to improve access to obstetrical care throughout the Commonwealth. The Secretary shall provide the report to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Health Care by November 1, 2004."

Appendix C

Rural Obstetrical Services Work Group Membership

The Honorable Jane H. Woods
Secretary of Health and Human Resources

Theodore (Tray) F. Adams, III
Partner
Troutman Sanders

Robert Agee, M.D.
Womens Health Center

Deren E. Bader, M.P.H.
Certified Professional Midwife

Christopher S. Bailey
Sr. Vice President
Virginia Hospital and Health Care Association

Thomas (Tom) S. Bridenstine
Principal Insurance Market Examiner
State Corporation Commission

Robin M. Broughman
Chief Nursing Officer
HCA Healthcare

Warren E. Callaway, FACHE
President/CEO
Danville Reg. Med. Ctr.

Rebecca J. Davis, Ph.D.
Executive Director
VA Rural Health Association

Doug H. Gray
Executive Director
Virginia Association of Health Plans

Gary R. Gutcher, M.D.
Professor of Pediatrics, Chair of Neonatal/Perinatal Medicine
MCV

Robert T. Hall
Trial Attorney
VA Association of Trial Attorneys (VTLA)

Appendix C

Rural Obstetrical Services Work Group Membership

The Honorable Emmett W. Hanger, Jr.
Member, Senate of Virginia
24th District

Jack L. Harris
VA Trial Lawyers Assoc.

Woodrow (Woody) Harris
Local Government

William N.P. Herbert, M.D.
Professor of OB & Gyn, Chair Dept. of OB and GYN
UVA

Robert A. Hofford, M.D.
Director of Family Practice Residency Program
Carilion Health Systems

B. H. Hubbard, III
Chairman, Board of Directors
Rappahannock General Hospital

Ann Hughes
Director of Legislative Affairs
Medical Society of Virginia

The Honorable Robert Hurt
Member of the Virginia House of Delegates
16th District

Elisabeth B. Hutton, Ph.D.
March of Dimes

JoAnne Jorgenson
Deputy Director
Fairfax Health District

Rod V. Manifold
Executive Director
Central VA Health Services

Matthew J. Meleski
Vice President
Network Management Southern Health Services, Inc.

Appendix C

Rural Obstetrical Services Work Group Membership

The Honorable Harvey B. Morgan
Member of the Virginia House of Delegates
98th District

William (Bill) R. Nelson, M.D.
Health Director
Chesterfield Health Department

Megan P. Padden
Director of Medicaid
Sentara Health Management

The Honorable Albert C. Pollard, Jr.
Member of the Virginia House of Delegates
99th District

Mark E. Rubin
Mediator/Trial Lawyer
The McCammon Group

Linda Cook Sawyer
Nurse Manager
Twin County Regional Healthcare

John W. Seeds, M.D.
Chairman, Obstetrics and Gynecology
MCV

Juliana van Olphen Fehr, C.N.M., Ph.D.
Coordinator, Nurse-Midwife
Shenandoah University

John B. Willey, M.D.
Private Practice
Winchester

Appendix D

Rural Localities as Defined by the Office of Management and Budget

Rural Localities

Accomack	Cumberland	Lancaster	Patrick	Surry
Alleghany	Dickenson	Lee	Prince Edward	Sussex
Amelia	Emporia	Lexington	Pulaski	Tazewell
Appomattox	Essex	Louisa	Radford	Waynesboro
Augusta	Floyd	Lunenburg	Rappahannock	Westmoreland
Bath	Franklin	Madison	Richmond	Winchester
Bland	Frederick	Martinsville	Rockbridge	Wise
Brunswick	Galax	Mecklenburg	Rockingham	Wythe
Buchanan	Giles	Middlesex	Russell	
Buckingham	Grayson	Montgomery	Shenandoah	
Buena Vista	Greensville	Nelson	Smyth	
Caroline	Halifax	Northampton	South Boston	
Carroll	Harrisonburg	Northumberland	Southampton	
Charlotte	Henry	Norton	Staunton	
Clifton Forge	Highland	Nottoway		
Covington	King and Queen	Orange		
Craig	King William	Page